New Jersey Department of Human Services

WAIVER SERVICES SUMMARY AND HEALTH PLAN COORDINATION

Health Plan Fax Numbers:	Date
☐ Healthfirst NJ .....1-866-506-7060 ☐ United Healthcare .....1-855-551-5912 ☐ Amerigroup .....1-877-244-1724 ☐ Horizon NJ Health.....1-609-583-3025 ☐ WellCare 1-973-274-2120	

WAIVER CARE/CASE MANAGEMENT (CM) AGENCY CONTACT INFORMATION

CM Name	Phone Number
Agency Name	Fax Number

PARTICIPANT INFORMATION

Participant Name	Participant Phone Number	Medicaid ID Number
Street Address	City, State, Zip Code	County

AUTHORIZED STATE PLAN SERVICES	FREQUENCY (DAYS/HOURS)
☐ Adult Day Health Services (ADHS)	
☐ Personal Care Assistant (PCA) ☐ Personal Preference Program (PPP):	
☐ Hospice Services:	
☐ Other (Specify):	

AUTHORIZED WAIVER SERVICES

☐ Global Options for Long Term Care	☐ Community Resources for People with Disabilities	☐ Traumatic Brain Injury	☐ AIDS Community Care Alternatives Program
Enrollment Date:	Enrollment Date:	Enrollment Date:	Enrollment Date:
☐ Care Management ☐ Attendant Care * ☐ Home-Based Supportive Care* ☐ Respite* ☐ Social Adult Day Care* ☐ Chore Service ☐ Environmental Adaptations ☐ Home-Delivered Meals ☐ PERS ☐ Special Medical Equip. & Supplies ☐ Transportation ☐ Caregiver/Recipient Training ☐ Assisted Living: (ALR or CPCH) ☐ AL Program in Sub Housing ☐ Adult Family Care ☐ Transitional Care Management ☐ Community Transition Services	☐ Case Management ☐ Private-Duty Nursing* ☐ Environmental/ Residential Modification ☐ Vehicle Modification ☐ PERS ☐ Community Transition Services	☐ Case Management ☐ Behavioral program ☐ Environmental/vehicle Modifications ☐ Community Residential Services ☐ Counseling ☐ Cognitive Rehabilitative Therapy ☐ Structured Day Program ☐ Supported Day Program ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech, Language and Hearing Therapy ☐ Respite Care *	☐ Case Management ☐ Private-Duty Nursing * ☐ Personal Care Assistant * Services (beyond the 40 hours available through the State Plan)

* Specify Frequency of Noted Waiver Services (Days/Hours):

Other (i.e., Informal Supports, Use of Participant-Employed Provider, or Name of AL Facility)

Information Updates (may include update from Health Plan on authorized services, etc.)

Completed By (Name and Title)	Agency Name
Signature	Phone Number